AIRBORNE LAW ENFORCEMENT ASSOCIATION

The Safety Wire

December 2015

Throttle Back just a touch for the holiday season. Sure, most of us still need to work in conditions that do not allow for relaxation just because the calendar says it is the holidays. But that is exactly the reason we need to slow down a touch and take a few extra moments to prepare for a flight or aircraft maintenance. There are extra stressors this time of year that conflict directly with our human desire to enjoy the holidays. To help you stay ahead of yuletide disasters, I have developed a list of seasonal risk items to add to your Flight Risk Assessment Tool (FRAT).

Hazard	Risk Score
Your family at your house > 3 days	+5
In-laws at your house > 3 days	+10
EGG NOG + Lactose Intolerance - Doors Off	+2
EGG NOG + Lactose Intolerance - Doors On	+12
"Jingle Bells" song stuck in head > 4 hours	+8
Missing holiday celebration to cover a shift	+10
Kid's Christmas list is bigger this year - paycheck is not	+14
Diet in last 24 hours mainly composed of candy canes, pie and Halloween candy stolen from your children	+15

Sale on laser light Christmas decorations in your area	+5
Leftover Thanksgiving turkey smells funny…but you're hungry for turkey	+18
A late call when you were trying to get off early to go to your kid's holiday performance at school	+126
The Santa you were asked to fly to a static display smells like bourbon	+10
"Winter wonderland" weather at 3am on a callout	+15
TCAS does not pick up flying reindeer	+12
Holiday meals have exceeded the range of the Velcro waist straps on your flightsuit	+18
Kids woke you up at 4:30am because "Santa was here!!!"	+20
TFO wears Santa hat instead of helmet	+1
Spent the day assembling toys instead of getting sleep for your shift	+45
Body is at work, mind is at home by the fireplace	+100
You did not laugh at any of these	+1000

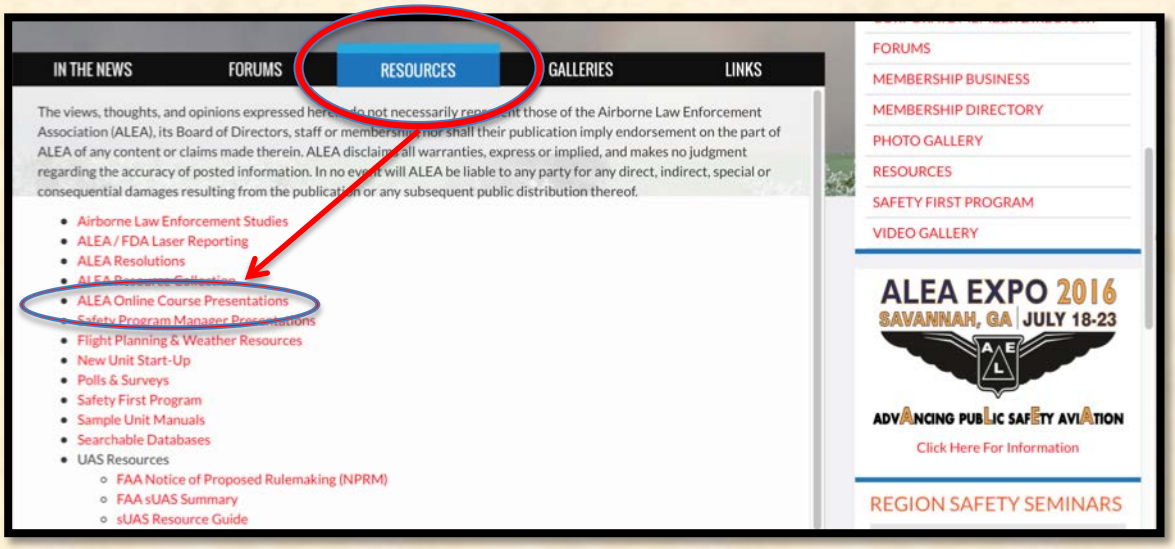
The mitigation for all of these is simple…realize that the stressors are there and throttle back a bit. Take a few extra minutes before a flight or maintenance task. When you feel rushed, pause and get a clearer picture of what is going on over the span of a few slow, deep breaths. Admit that family, friends, money, expectations, work and a million other things will affect you in positive and negative ways more so this time of year, *all* of which in turn affect you at work. Don't pretend you can leave it all at the door when you come to work. Know that it is there and deal with it. Give yourself the time, rest, nutrition and mental breaks needed to make it through this season. Take care of one another, stay sharp, but give yourself an extra minute… and enjoy the holidays.

"The smallest amount of vanity is fatal in aeroplane flying. Self-distrust rather is the quality to which many a pilot owes his protracted existence."

~ Edward "Eddie" Rickenbacker
Top scoring US Ace during WWI

Free Online Training

New classes are available on the ALEA website. There are now seven online courses and two SMS webinars. We will continue to post new classes in 2016.



Safety Officer Training

We have had a number of requests from ALEA members about annual currency training for safety officers who have already gone through an initial course. During each ALEA regional seminar in 2016, we will be dedicating 1.5 hours of the safety roundtable session to safety officer refresher training. For anyone requiring a record of attendance, we will provide a certificate upon request. This session will still be open to any ALEA member interested in safety. There will be something to learn for anyone attending, safety officer or not. The remaining 1.5 hours of the safety roundtable will still be an open discussion about safety issues. Please contact me if you have any questions or suggestions. Hope to see you all there.

Resources

If you are not familiar with the Concern Network, it is a great resource worth checking out (http://www.concern-network.org). It was organized by the medical transport industry as a means of relaying information about accidents and incidents involving medical crews. Many of the reports are in aircraft and flight profiles very similar to many public safety aviation flights. If you want to receive the notifications, go to the website and click on the 'subscribe' button. The coordinator of the program asked that you mention that you are a member of ALEA and he will approve the request. Below is an example of one of their alerts:

Description:

Approximately four minutes in flight, responding to a scene call, the

aircraft was traveling at approximately 1,000 feet AGL. The PIC noticed a large bird at approximately the same altitude and altered his course. The bird, an American buzzard, also altered its course on a direct path to the aircraft. The PIC banked the aircraft to try and prevent contact, but the bird flew directly under the rotor disc and

entered the aircraft via the right rear greenhouse window. The flight paramedic, who was sitting in the right seat and wearing his helmet with the visor down, was struck in the head and face by the bird, along with pieces of the window and damaged interior.

The PIC was in contact with our communications center at the time and elected to make a precautionary landing in a clear field that was directly ahead. Once he had landed the aircraft safely and was secure, he and the flight nurse assessed the flight paramedic and found some minor injuries. Fire, EMS, and police were notified and the flight paramedic was transported to the local hospital. He was evaluated, treated and released with minor injuries.

All crew returned to the base and debriefed. The communication center accurately activated the PAIP and full activation was completed through the corporate path and regional path. The aircraft was subsequently removed from the field, via ground efforts, and taken to the program maintenance facility where it has undergone repair and should be returned to service.

Additional Info:
The flight paramedic also evaluated this as a very good learning point as he had his helmet on and the visor down. Without these safety devices, he surmised that he would have had far worse injuries to his head and face and shows the importance of a helmet and the visors.

"There is nothing noble in being superior to your fellow man. True nobility is being superior to your former self."

~ Ernest Hemingway

Reality Check...

Note: *The following reports are taken directly from the reporting source and edited for length. The grammatical format and writing style of the reporting source has been retained. My comments are added in red where appropriate. The goal of publishing these reports is to learn from these tragic events and not to pass judgment on the persons involved.*

Aircraft: Bell 206 L4
Injuries: 2 Fatal
NTSB#: WPR15FA072

http://www.ntsb.gov/_layouts/ntsb.aviation/brief.aspx?ev_id=20150101X15630&key=1

http://www.tucsonnewsnow.com/story/27741412/cochise-county-sheriffs-helicopter-crashes-near-the-benson-area

On December 31, 2014, at 1710 mountain standard time, a Bell 206 L4, collided with terrain 7 miles west of Benson, Arizona. The commercial pilot and pilot rated mechanic were fatally injured, and the helicopter was destroyed. The helicopter was operated by Airwest Helicopters as [a] Part 91 positioning flight [under contract to the Sheriff's Office]. Visual meteorological conditions prevailed for the flight, which operated on a company visual flight rules flight plan. The flight originated form Glendale, Arizona, at 1550, and was destined for Sierra Vista, Arizona.

The operator reported that the helicopter had not arrived at its destination and that the Sky Connect Tracking System indicated that the helicopter was at a stationary location between Tucson and Benson. The Cochise County Sheriff located the helicopter wreckage about 2030 at the location the Sky Connect system was reporting. The helicopter was fragmented into multiple pieces along a 174-foot-long debris path. Witnesses living in the local area reported hearing a low flying helicopter around the time of the accident, and that the visibility at ground level was very limited, with low clouds and fog.

Aircraft: Raytheon G36
Injuries: 4 Fatal
NTSB#: CEN14FA249

http://www.ntsb.gov/_layouts/ntsb.aviation/brief.aspx?ev_id=20140523X02239&key=1&queryId=6851409e-90ad-4a65-bb9c-650e44ad7bda&pgsize=50

The airplane was returning from a local flight and the pilot flew a tight downwind leg for landing on runway 35, possibly due to a direct crosswind in excess of 20 knots. During the base turn, the airplane overshot the final course, and the pilot used at least 60 degrees of bank to correct the airplane back on course and over the runway. The airplane

then bounced and touched down at least 20 knots above the manufacturer's published approach speed with about 1,810 ft. remaining on the runway. The airplane's airspeed began to rapidly decrease, but then several seconds later, the airplane's airspeed increased as the pilot rejected the landing. The airplane did not gain significant altitude or airspeed then began a slight right turn. The airplane's roll rate then sharply increased, and the airplane quickly descended, consistent with a stall, before colliding with a transmission wire and terrain. Examination of the airframe and engine did not reveal any preimpact anomalies that would have precluded normal operation. Strong, variable, gusty wind, with an environment conductive to the formation of dry microbursts, was present at the airport at the time of the accident. Several lightning strikes were recorded in the vicinity of the accident site around the time of the accident. It is unknown if the presence of lightning or wind impacted the pilot's inflight decision-making in the pattern, on approach, or during the attempted go-around. The circumstances of the accident are consistent with an in-flight encounter with a strong tailwind and/or windshear during climbout after the rejected landing.

The National Transportation Safety Board determines the probable cause(s) of this accident as follows:

The airplane's encounter with a strong tailwind and/or windshear, which resulted in an inadvertent stall. Contributing to the accident was the pilot's continuation of the unstable approach, long landing, and delayed decision to conduct a go-around.

Aircraft: AS350 B3e
Injuries: 2 Fatal
NTSB#: WPR16FA029

http://www.ntsb.gov/_layouts/ntsb.aviation/brief.aspx?ev_id=20151118X05037&key=1

http://ktla.com/2015/11/18/helicopter-spins-out-of-control-before-catching-fire-after-crashing-in-carlsbad-2-dead/

On November 18, 2015, about 1624 Pacific standard time, an Airbus Helicopters AS350B3E departed controlled flight while landing on a moveable helipad. The pilot, who was the owner, was operating the helicopter under the provisions of 14 Code of Federal Regulations Part 91. The private pilot and private pilot-rated passenger were fatally injured; the helicopter sustained substantial damage.

Upon returning, the helicopter approached the airport from the northeast and was cleared to land on runway 24. It descended to midfield, turned left, and approached the ramp in a low hover via taxiway A3. The helicopter then followed taxiway A and began an approach to the helipad from the east and into the direction of the sun. The helicopter then landed short of the helipad, with the center of its skids making contact with the pad's front edge. The helicopter immediately rocked back and its tailskid struck the ground. The helicopter then began a series of back and forth oscillations, and the helipad broke free from the rear left chock, rotated to the right, and pivoted around its front right wheel. The helicopter spun with the helipad for the first quarter of the turn, and then rapidly climbed and rotated 270 degrees to the right. The helipad came to rest to the north, having revolved 180 degrees, and about 50 seconds later the helicopter landed on the tarmac east of the helipad, while partially straddling taxiway A and the ramp at a 45-degree angle.

For the next 2 1/2 minutes line crew re-secured the helipad, installing chocks on three of the four wheels. The helicopter then repositioned for an approach to the helipad from the west. During the next 4 1/2 minutes the helicopter made three landing attempts, getting to within 5 to 20 ft of the helipad. A video of the final landing attempt was captured by a witness, who was located about 130 ft south. He had observed the other landing attempts and was concerned that the helicopter may crash, so positioned himself behind a car at the corner of the FBO's hangar.

The video revealed that the helicopter again landed short of the pad, similar to the first landing attempt, rocking back and forth twice onto its tailskid. After the final strike, the helicopter pitched violently forward and out of view behind the hangar. Security cameras revealed that from here the helicopter spun 180 degrees to the left, and after reaching a 45-degree nose up attitude, the aft tailrotor and vertical stabilizer assembly struck the ground and separated. The helicopter bounced and rotated another 360 degrees before landing hard on its left side. Once on the ground, the main rotor blades and cabin continued to spin with the engine still running. The helicopter continued spinning for the next 5 minutes and 10 seconds while slowly sliding about 530 ft east along the ramp. The tailboom and horizontal stabilizer then separated and the helicopter rolled onto its side, shedding the main rotor blades. The engine continued operating for another 30 seconds while fire crew doused the helicopter. White smoke billowed from the engine's exhaust after the helicopter came to rest, but there was no indication of fire.

The pilot purchased the helicopter on October 29, 2015, but had flown demonstration and familiarization flights in it since September 20. According to the helicopter's maintenance records, those flights totaled about 8.8 hours, and were all conducted with a certified flight instructor present. He received an additional 2 hours of flight training on November 13.

According to friends and flight instructors who had flown with the pilot, he had previously owned a Bell 407, and the accident flight was the first he had flown in the AS350 series without a professional pilot present.

Aircraft: Cessna T210M
Injuries: 1 Fatal
NTSB#: CEN15FA027

http://www.ntsb.gov/_layouts/ntsb.aviation/brief.aspx?ev_id=20141025X20212&key=1&queryId=6851409e-90ad-4a65-bb9c-650e44ad7bda&pgno=1&pgsize=50

The non-instrument rated pilot departed on a cross-country flight. When the airplane was reported overdue by family members, a search was initiated, and the airplane wreckage was located about 3 miles from a regional airport. Witnesses reported seeing an airplane maneuvering near the airport about the time of the accident; one witness reported it was in a steep bank. That witness reported the weather as “murky” with a low overcast sky and an estimated visibility of 3 miles; another witness reported there was a light breeze and drizzle. The automated weather reporting station at the airport recorded a 900-ft overcast ceiling and 5 miles visibility in mist. Additionally, weather reports and forecasts along the route of flight included overcast clouds and instrument flight rules (IFR) conditions. There was no record of the pilot obtaining a weather briefing for the flight. Examination of the wreckage did not reveal any anomalies that would have precluded normal operations. It is likely that the pilot entered IFR conditions on approach to the airport, was unable to maintain visual references, and subsequently lost control of the

airplane.

The National Transportation Safety Board determines the probable cause(s) of this accident as follows: The non-instrument rated pilot's continued visual flight into instrument flight rules conditions, which resulted in an in-flight loss of control.